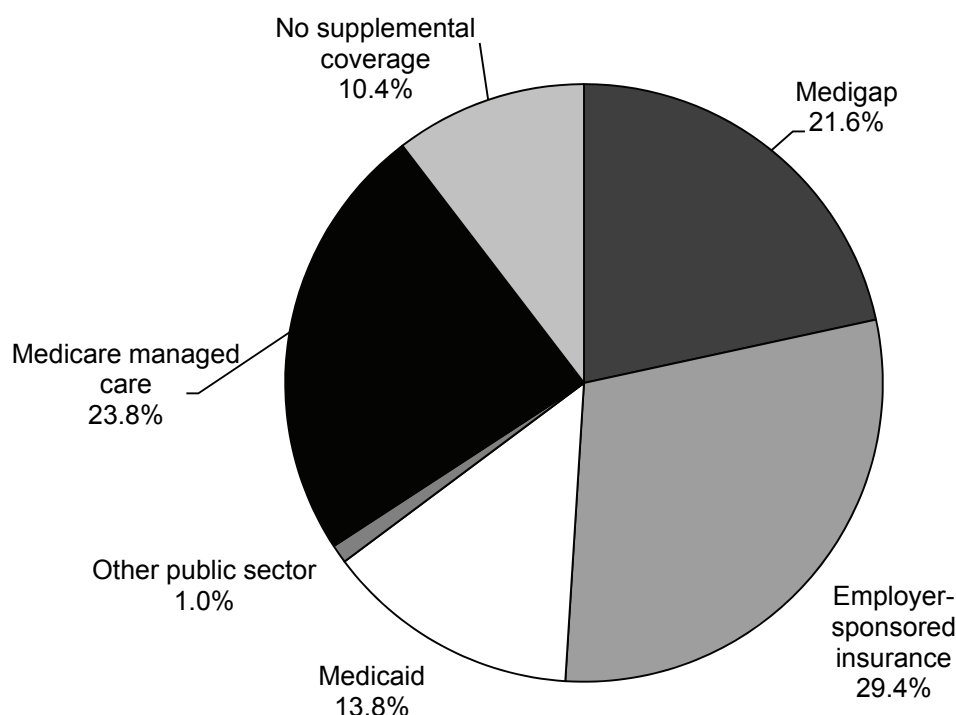


SECTION

3

Medicare beneficiary and other payer financial liability

Chart 3-1. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, 2010



Note: Beneficiaries are assigned to the supplemental coverage category they were in for the most time in 2010. They could have had coverage in other categories during 2010. "Other public sector" includes federal and state programs not included in other categories. Analysis includes only beneficiaries not living in institutions, such as nursing homes. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2010 or who had Medicare as a secondary payer.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file 2010.

- Most beneficiaries living in the community (noninstitutionalized) have coverage that supplements or replaces the Medicare benefit package. In 2010, about 90 percent of beneficiaries had supplemental coverage or participated in Medicare managed care.
- About 51 percent of beneficiaries had private-sector supplemental coverage such as medigap (about 22 percent) or employer-sponsored retiree coverage (about 29 percent).
- Slightly less than 15 percent of beneficiaries had public-sector supplemental coverage, primarily Medicaid.
- Twenty-four percent of beneficiaries participated in Medicare managed care. This care includes Medicare Advantage, cost, and health care prepayment plans. These types of arrangements generally replace Medicare's fee-for-service coverage and often add to it.

Chart 3-2. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, by beneficiaries' characteristics, 2010

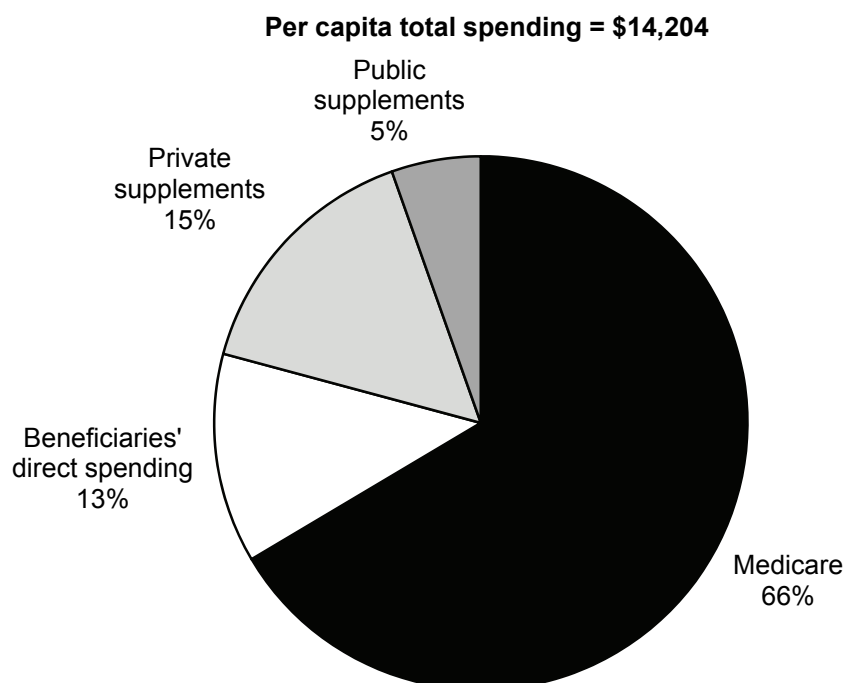
	Number of beneficiaries (thousands)	Employer-sponsored insurance	Medigap insurance	Medicaid	Medicare managed care	Other public sector	Medicare only
All beneficiaries	41,047	29%	22%	14%	24%	1%	10%
Age							
<65	6,359	13	5	44	18	1	19
65–69	9,542	33	21	8	25	0	12
70–74	8,196	31	25	8	26	2	8
75–79	6,827	32	26	9	26	1	7
80–84	5,284	33	26	8	25	1	7
85+	4,840	33	29	9	20	1	8
Income category							
< \$10,000	5,125	8	8	57	18	0	8
\$10,000–\$19,999	11,702	17	19	21	25	2	15
\$20,000–\$29,999	8,959	33	24	3	28	1	12
\$30,000–\$39,999	4,601	39	24	1	28	0	8
\$40,000–\$59,999	5,297	43	28	0	21	0	7
\$60,000–\$79,999	2,257	47	28	0	20	1	6
≥ \$80,000	3,107	49	27	0	18	0	6
Eligibility status							
Aged	34,468	32	25	8	25	1	9
Disabled	6,148	13	5	43	18	1	19
ESRD	403	22	18	43	12	0	5
Residence							
Urban	31,271	30	20	13	27	1	10
Rural	9,777	29	28	18	12	1	12
Sex							
Male	18,282	31	19	13	25	1	12
Female	22,765	28	24	15	23	1	9
Health status							
Excellent/very good	18,265	34	24	7	25	1	10
Good/fair	19,587	27	20	18	24	1	10
Poor	2,976	18	16	31	18	2	15

Note: ESRD (end-stage renal disease). Beneficiaries are assigned to the supplemental coverage category they were in for the most time in 2010. They could have had coverage in other categories during 2010. Medicare managed care includes Medicare Advantage, cost, and health care prepayment plans. "Other public sector" includes federal and state programs not included in other categories. Married people have joint income reported on the data file. We divided their income by 1.26 to create an equal measure with unmarried people. "Urban" indicates beneficiaries living in metropolitan statistical areas (MSAs). "Rural" indicates beneficiaries living outside MSAs. Analysis includes beneficiaries living in the community. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2010 or who had Medicare as a secondary payer. The number of beneficiaries differs among boldface categories because we excluded beneficiaries with missing values. Numbers in rows may not sum to 100 due to rounding.

Source: MedPAC analysis of 2010 Medicare Current Beneficiary Survey, Cost and Use file.

- Beneficiaries most likely to have employer-sponsored supplemental coverage are those who are above age 64, have income over \$20,000, are eligible due to age, and report better than poor health.
- Medigap is most common among those who are age 70 or older, have income over \$20,000, are eligible due to age or ESRD, are rural dwelling, are female, and report excellent or very good health.
- Medicaid coverage is most common among those who are under age 65, have income below \$20,000, are eligible due to disability or ESRD, are rural dwelling, and report poor health.
- Lack of supplemental coverage (Medicare coverage only) is most common among beneficiaries who are under age 65, have income of \$10,000 to \$30,000, are eligible due to disability, are male, and report poor health.

Chart 3-3. Total spending on health care services for noninstitutionalized FFS Medicare beneficiaries, by source of payment, 2010

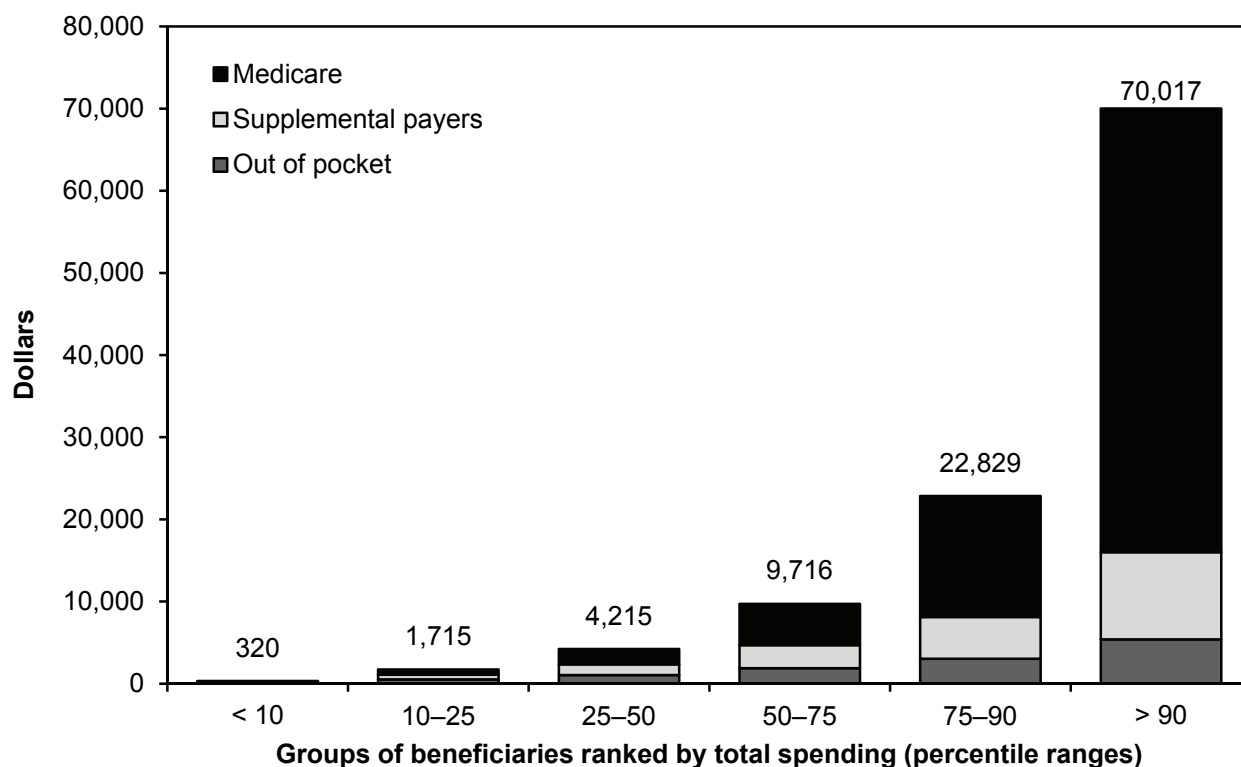


Note: FFS (fee-for-service). "Private supplements" includes employer-sponsored plans and individually purchased coverage. "Public supplements" includes Medicaid, Department of Veterans Affairs, and other public coverage. Direct spending is on Medicare cost sharing and noncovered services but not supplemental premiums. Analysis includes only FFS beneficiaries not living in institutions such as nursing homes.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file 2010.

- Among FFS beneficiaries living in the community, the total cost of health care services (defined as beneficiaries' direct spending as well as expenditures by Medicare, other public-sector sources, and all private-sector sources on all health care goods and services) averaged about \$14,200 in 2010. Medicare is the largest source of payment: It pays 66 percent of the health care costs for FFS beneficiaries living in the community, an average of \$9,436 per beneficiary. The level of Medicare spending in this chart differs from the level in Chart 2-1 because this chart excludes beneficiaries in Medicare Advantage and those living in institutions, while Chart 2-1 represents all Medicare beneficiaries.
- Private sources of supplemental coverage—primarily employer-sponsored retiree coverage and medigap—paid 15 percent of beneficiaries' costs, an average of \$2,189 per beneficiary.
- Beneficiaries paid 13 percent of their health care costs out of pocket, an average of \$1,811 per beneficiary.
- Public sources of supplemental coverage—primarily Medicaid—paid 5 percent of beneficiaries' health care costs, an average of \$768 per beneficiary.

Chart 3-4. Per capita total spending on health care services among noninstitutionalized FFS beneficiaries, by source of payment, 2010

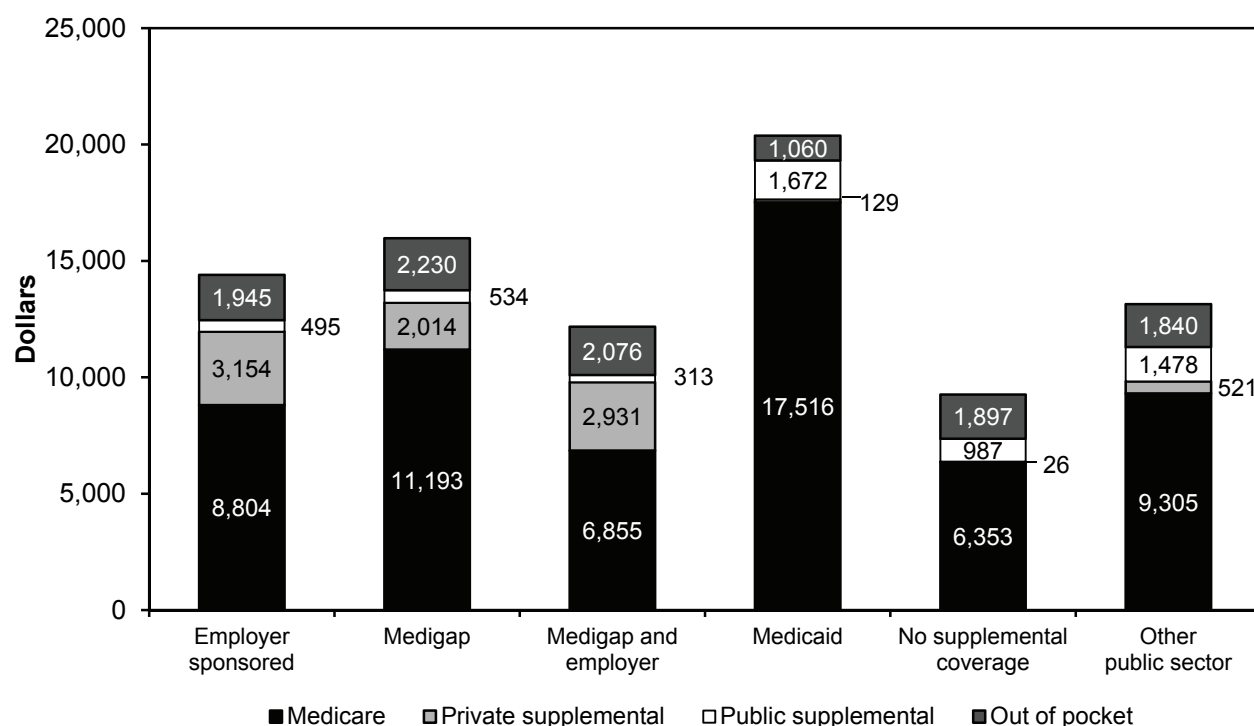


Note: FFS (fee-for-service). Analysis excludes those who are not in FFS Medicare and those living in institutions such as nursing homes. Out-of-pocket spending includes Medicare cost sharing and noncovered services.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file 2010.

- Total spending on health care services varies dramatically among FFS beneficiaries living in the community. Per capita spending for the 10 percent of beneficiaries with the highest total spending averaged \$70,017 in 2010. Per capita spending for the 10 percent of beneficiaries with the lowest total spending averaged \$320.
- Among FFS beneficiaries living in the community, Medicare pays a larger percentage as total spending increases, and beneficiaries' out-of-pocket spending is a smaller percentage as total spending increases. For example, Medicare pays 66 percent of total spending for all beneficiaries, but pays 77 percent of total spending for the 10 percent of beneficiaries with the highest total spending. Beneficiaries' out-of-pocket spending covers 13 percent of total spending for all beneficiaries, but only 8 percent of total spending for the 8 percent of beneficiaries with the highest total spending.

Chart 3-5. Variation in and composition of total spending among noninstitutionalized FFS beneficiaries, by type of supplemental coverage, 2010

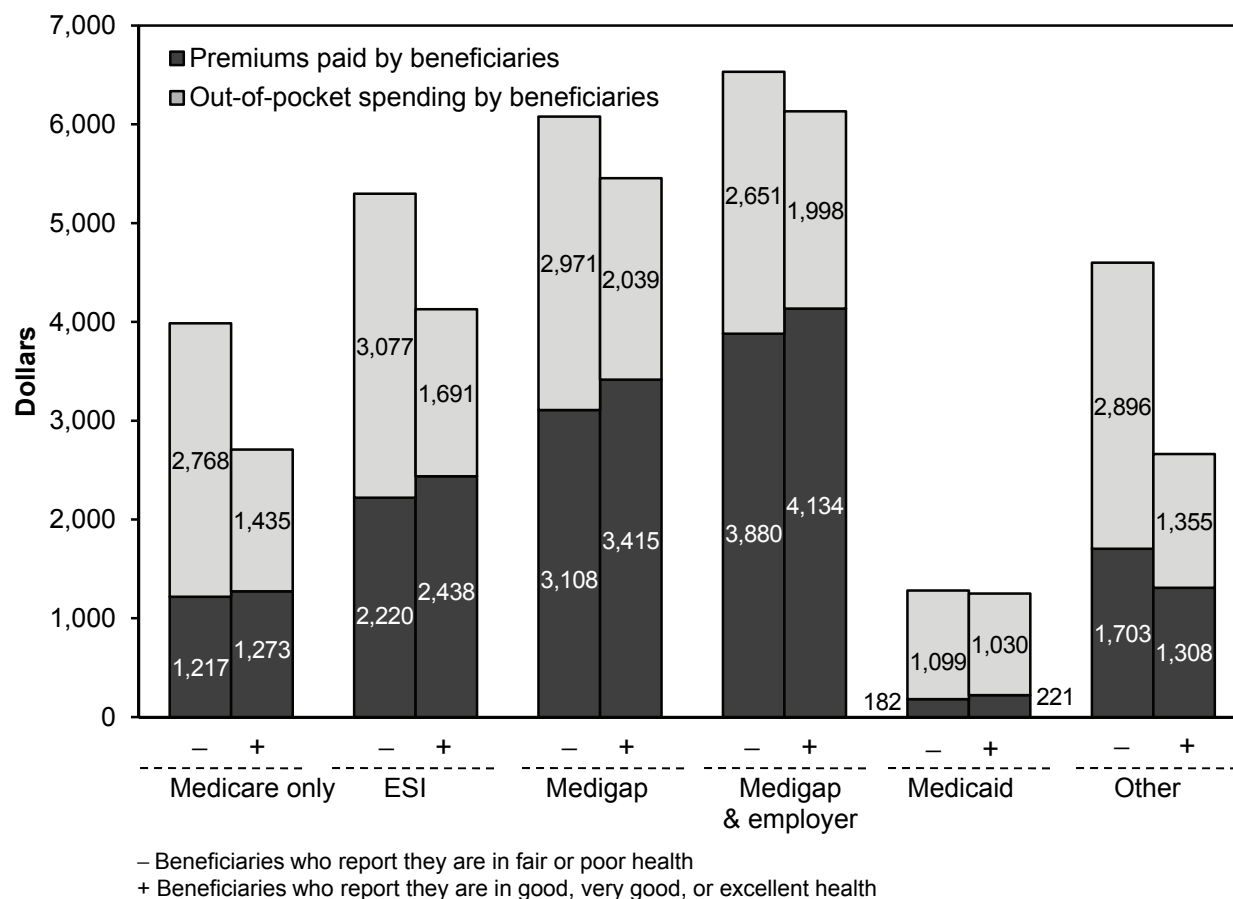


Note: FFS (fee-for-service). Beneficiaries are assigned to the supplemental coverage category they were in for the most time in 2010. They could have had coverage in other categories during 2010. "Other public sector" includes federal and state programs not included in the other categories. "Private supplemental" includes employer-sponsored plans and individually purchased coverage. "Public supplemental" includes Medicaid, Department of Veterans Affairs, and other public coverage. Analysis excludes beneficiaries who are not in FFS Medicare or live in institutions such as nursing homes. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2010 or had Medicare as a second payer. Out-of-pocket spending includes Medicare cost sharing and noncovered services, but not supplemental premiums.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file 2010.

- The level of total spending (defined as beneficiaries' out-of-pocket spending as well as expenditures by Medicare, other public-sector sources, and all private-sector sources on all health care goods and services) among FFS beneficiaries living in the community varies by the type of supplemental coverage they have. Total spending is much lower for those beneficiaries with no supplemental coverage than for those beneficiaries who have supplemental coverage. Beneficiaries with Medicaid coverage have the highest level of total spending—120 percent higher than those with no supplemental coverage in 2010.
- Medicare is the largest source of payment for beneficiaries in each supplemental insurance category, but the second largest source of payment differs. Among those with supplemental coverage, combined public and private supplemental coverage is the second largest source of payment. Among those who are covered only by Medicare, beneficiaries' out-of-pocket spending is the second largest source of payment.

Chart 3-6. Out-of-pocket spending for premiums and health services per beneficiary, by insurance and health status, 2010



Note: ESI (employer-sponsored supplemental insurance).

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file 2010.

- This diagram illustrates out-of-pocket spending on services and premiums by beneficiaries' supplemental insurance and health status. For example, beneficiaries who have only traditional Medicare coverage ("Medicare only") and report fair or poor health averaged \$1,217 in out-of-pocket spending on premiums and \$2,768 on services in 2010. Those who have Medicare-only coverage and report good, very good, or excellent health averaged \$1,273 in out-of-pocket spending on premiums and \$1,435 on services.
- Insurance that supplements Medicare does not shield beneficiaries from all out-of-pocket costs. Beneficiaries who report being in fair or poor health spend more out of pocket for health services than those reporting good, very good, or excellent health, regardless of the type of coverage they have to supplement Medicare.
- Despite having supplemental coverage, beneficiaries who have ESI or medigap have out-of-pocket spending that is comparable to or more than those who have only coverage under traditional Medicare (Medicare only). This result likely reflects the fact that beneficiaries who have ESI or medigap have higher incomes and are likely to have stronger preferences for health care.
- What beneficiaries actually pay out of pocket varies by type of supplemental coverage. For those with medigap, out-of-pocket spending generally reflects the premiums and costs of services not covered by Medicare. Beneficiaries with ESI usually pay less out of pocket for Medicare noncovered services than those with medigap, but may pay more in Medicare deductibles and cost sharing.